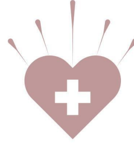

Homeostasis Medicine
Dr. Brittany Pickett-Rose, DACM, LAc.
drpickettrose@gmail.com
(650) 888-5408

PATIENT INFORMATION Today's Date:______________

Patient Name: _________________________________

Address:____

Home # : _____________________Work #: _____________________Cell #:__________________

May we leave a message at these phone numbers? Yes / No

Email Address: ____________________________________

Patient Status

Birth Date:_______________________ Age: ___________

Gender: M___ F___ Transgender___ Other_______

How would you like to be addressed?______________________________

Married ___ Single ___ Divorced ___ Widowed ____ Partnered ____ Other ________________

Emergency Contact: ____

Relationship:___________________________

Emergency Contact Telephone #: ____

Referred By: ____

Primary Health Care Source

Physician's Name:__________________________Telephone #: ____________________________

Physician's Address: ____

What are you being treated for?

____

Date of Injury or Onset of Illness:

____

Insurance Company:

ID Number:

Group Number:

WELCOME !

Initial Health History Form

What health chief complaint do you want treated?

Have you ever had an acupuncture treatment?

Are you presently being treated for a medical condition? Please describe.

Do you have any chronic pain?

Do you have other health concerns?

Diet

Please describe the type of foods you eat regularly:

Are your meals mostly raw or cooked?

Breakfast/Morning Snack

Lunch/Afternoon Snack

Dinner/Evening Snack

Exercise

Do you exercise regularly? Yes ____ How often? __________________ / No ____

What type of exercise do you do?

Western Medicine (circle any of the following that you are now taking)

Aspirin antacids oral contraceptives Fiber supplements

Blood Pressure Meds. ibuprofen acetaminophen (Tylenol)

Laxatives Diet pills Tranquilizers Sleeping pills Hay fever tablets

Blood Thinning Meds. Insulin/Diabetic pills

OTHERS:

Natural Medicinals

Vitamins____

Supplements ____

Herbal Prescriptions_______________________________________

Allergies

Natural Allergic Reactions?______________________________

Drug Allergies? ____

Latex Allergy?____

Additional Comments:

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Coffee yes no per day/week_____ age started______________ Cups per day:

Tobacco yes no per day/week_____ age started______________ Cigs per day:

Marijuana yes no per day/week_____ age started______________Amount per day:

Alcohol yes no per day/week_____ age started______________Glass per day:

Crack/Cocaine yes no per day/week______ age started______________Amount per day:

Heroin yes no per day/week______ age started______________Amount per day:

Other:____

Family History

Complete for each family member, placing an X in the appropriate box:

	Self	Father	Mother	Sister	Brother
Allergies					
Blood disorder					
Diabetes					
Cancers or Tumors					
Seizures					
High Blood Pressure					
Kidney or Bladder disorders					
Stomach or Intestinal Disorders					
Drug Abuse					
Tuberculosis					
Heart Disease					
Stroke					
Mental Illness Anxiety/Depression					
Other					
Age of Death					

Major Hospitalizations

Have ever been hospitalized for any serious medical illness or operation?:

Write in your most recent hospitalizations below including Date of Operation:

Females

Currently Pregnant? ____ If yes, for how long? ______________________

Total Pregnancies____Living____Ectopic___Misscariages___Induced Abortions___

Checkmark all that apply and indicate if your symptoms are Current (C) or of the Past (P)

GENERAL
Poor appetite
Excessive appetite
Insomnia
Fatigue
Fevers
Night sweats
Sweat easily
Chills
Localized weakness
Poor coordination
Change in appetite
Strong thirst

SKIN AND HAIR
Rashes
Hives
Itching
Eczema
Pimples
Dryness
Tumors/lumps

HEAD AND NECK
Fainting
Neck stiffness
Enlarged lymph glands
Headaches
Concussions
Dizziness

EARS
Infection
Ringing
Decreased hearing
Discharge

EYES
Blurred vision
Visual changes
Poor night vision
Spots
Cataracts
Glasses/Contacts
Eye inflammation

NOSE, THROAT, AND MOUTH
Nose bleeds
Sinus infection
Hay fever or allergies
Recurring sore throats
Grinding teeth
Difficulty swallowing

CARDIOVASCULAR
High blood pressure
Low blood pressure
Blood clots
Palpitations
Fainting
Phlebitis
Chest pain/Angina
Irregular heartbeat
Cold hands/feet
Swelling of hands/feet
Pacemaker

RESPIRATORY
Asthma
Bronchitis
Frequent colds
Pneumonia
Cough
Coughing blood
Production of phlegm
Emphysema
Shortness of breath
Chronic obstructive pulmonary disease

GASTRO-INTESTINAL
Nausea
Vomiting
Diarrhea/Loose Stools
Belching
Blood in stools
Black stools
Bad breath
Rectal pain/Hemorrhoids
Constipation
Pain or cramps
Indigestion
Gallbladder disorder
Gas
IBS (Irritable Bowel Syn)
Heartburn

GENITOURINARY
Kidney stones
Pain on urination
Frequent urination
Blood in urine
Urgency to urinate
Unable to hold urine

FEMALE
Frequent urinary tract infections
Frequent vaginal infections
Pain/itching of genitalia
Genital lesions/discharge
Pelvic inflammatory disease
Abnormal pap smear
Irregular periods
Painful menstrual periods
Premenstrual syndrome
Abnormal bleeding
Menopausal syndrome
Breast lumps

MALE
Pain/itching of genitalia
Genital lesions/discharge
Impotence
Weak urinary stream
Lumps in testicles
Prostatitis

NEUROLOGICAL
Seizures
Tremors
Numbness or tingling of limbs
Concussion
Pain
Paralysis

PSYCHOLOGICAL
Depression
Anxiety/Stress
Irritability
Emotional/Psychological issues
Mania/bipolar
PTSD

OTHER
Please Explain: